OSSIPEE RIVER DENTAL

PERSONAL INFORMATION

Name _____ Birth Date _____ Social Security # _____

Preferred Name _____ Sex: ❑ Female ❑ Male

Mailing Address _____

Physical Address _____

Occupation: _____ Employer Name & Address _____

Phones: Home _____ Cell _____ Work _____

e-mail _____

Please circle preferred method of contact: ____ Phone ____ email ____ Text

Marital Status: ❑ Single ❑ Married ❑ Partner ❑ Divorced ❑ Separated ❑ Widowed ❑ Child

Spouse name: _____

Parent information (if patient is a child):

Name: _____ Birth Date _____ Daytime phone _____

Social Security # _____ Mailing Address _____

Is any other member of your family a patient in our practice? _____ Who? _____

If new to Sacopee Valley Family Dental, who may we thank for recommending our office to you? _____

PRIMARY INSURANCE INFORMATION

Name of Insured _____ Relationship to Patient ❑ Patient ❑ Spouse ❑ Child ❑ Other: _____

Employer Name & Address _____

Employer Address 2 _____

Insurance Company Name & Address _____

Insurance Company Address 2 _____

Carrier ID _____ Soc. Sec. # _____ Date of Birth _____

SECONDARY INSURANCE INFORMATION

Name of Insured _____ Relationship to Patient ❑ Patient ❑ Spouse ❑ Child ❑ Other: _____

Employer Name & Address _____

Employer Address 2 _____

Insurance Company Name & Address _____

Insurance Company Address 2 _____

Carrier ID _____ Soc. Sec. # _____ Date of Birth _____

CONSENT FOR SERVICES

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I hereby give my permission for the use of photographs, made in the process of examination and treatment for purposes of consultations, research, education & publication.

_____ _____ _____

Signature of patient, parent or guardian | Date | Relationship to Patient

_____ _____ _____

Signature of Guarantor of payment/responsible party | Date | Relationship to Patient

OSSIPEE RIVER DENTAL

FINANCIAL POLICY

We are committed to your treatment being successful and to providing the highest quality dental services at a reasonable fee. Please understand that payment of your bill is necessary in order for us to provide treatment.

PATIENTS WITH DENTAL INSURANCE

As a courtesy to our patients, we prepare and process all insurance forms. However, having insurance does not release the patient from responsibility. Our expectations of you as the owner of the policy are as follows:

1. Estimated patient portions must be paid at the time of service. This may include co-payments, deductibles, co-insurance and/or non-covered procedures.
2. You are responsible for educating yourself about the details of your policy which includes deductibles, yearly maximums, and policy exclusions.
3. If the insurance company does not pay our office within 60 days, if is your responsibility to pay using one of the payment methods listed below. The insurance policy belongs to you and we have no leverage to obtain payment.

A rebilling charge of 1.5% per month (annual percentage rate of 18%) will be assessed on any unpaid balance over 90 (ninety) days regardless of insurance estimates. Insurance estimates are based on limited information provided to our office by your insurance company and is not a guarantee of coverage or payment.

PATIENTS WITHOUT DENTAL INSURANCE

If you have no insurance coverage, full payment is due at the time of service with one of the payment options listed below.

PAYMENT OPTIONS

For your convenience, you may choose any of the following methods of payment:

- Cash
- Personal Check, postdated if necessary (returned check fee will be charged at $35 per check)
- Visa, MasterCard, Discover, American Express – Credit or Debit
- Extended Payment Plan with our Financing Partner, Care Credit. Short-term plans may be available with no interest. Credit approval must be received prior to treatment.
- Payment Plans may be available at the office's discretion. Arrangements must be made prior to treatment.

SHORT NOTICE CANCELLATIONS & MISSED APPOINTMENTS

Please make every effort to keep your scheduled appointments. If you must cancel or reschedule, kindly notify us at least 24 hours in advance. There is a $35 charge for all appointments that are cancelled or missed without a 24 hour notice.

MINOR PATIENTS

The parent, guardian, or adult accompanying and signing all forms for a minor will be responsible for full payment. Parents or guardians must be present to authorize all dental treatment for minors.

Release of Information and Insurance Payment Authorizations

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payers, and/or healthcare practitioners. I hereby authorize and direct payment of dental benefits otherwise payable to me, directly to the dentists at Sacopee Valley Family Dentistry.

FINANCIAL AGREEMENT

I understand that I am financially responsible for all charges incurred by my dependent(s), or myself, whether or not covered by insurance. I agree to pay Sacopee Valley Family Dentistry for professional services rendered to me or my dependent(s) at the time of service. If my insurance pays less than estimated, I agree to pay any remaining balance within 30 (thirty) days of billing. I expressly agree to pay all costs of collection agency fees assessed at 40% of the total amount due, and all court costs and attorney fees, if these terms are not met.

Signature:_____ Date: _____

(Patient, legal guardian or authorized agent of patient)

OSSIPEE RIVER DENTAL

HEALTH HISTORY & COMMUNICATION

*Updated Annually

Patient Legal Name: _____ (First / MI / Last) Date of Birth: _____

Mailing Address: _____ (City / State / Zip)

Parent(s)/Legal Guardian(s): (only if patient is a minor) _____

HOME ( ) _____ Okay to leave message? ❑ Yes ❑ No **Extended Message? ❑ Yes ❑ NO

CELL ( ) _____ Okay to leave message? ❑ Yes ❑ No **Extended Message? ❑ Yes ❑ NO

WORK ( ) _____ Okay to leave message? ❑ Yes ❑ No **Extended Message? ❑ Yes ❑ NO

***extendend messages may conatin clinical and/or prescription info*

E-Mail Address: _____ Employer: _____

Emergency Contact Name: _____ Relationship: _____

Home: _____ Cell: _____ Work: _____

Are you required to take a pre-med for dental appointments?	❑ Yes	❑ No
Do you have Dental Anxiety?	❑ Yes	❑ No
Have you ever been hospitalized or had a major operation?	❑ Yes	❑ No
Have you ever had a serious head or neck injury?	❑ Yes	❑ No
Do you use tobacco?	❑ Yes	❑ No
Do you use controlled substances?	❑ Yes	❑ No
Are you pregnant, trying to get pregnant, nursing, or taking oral contraceptives?	❑ Yes	❑ No

Please list all medications you are currently taking.
Please include prescriptions and over the counter medications.

_____

_____

ALLERGIES – Check all that apply.

- ❑ Aspirin
- ❑ Acrylic
- ❑ Amoxicillin
- ❑ Codeine
- ❑ Ceclor
- ❑ Erythromycin
- ❑ Epinephrine
- ❑ Other
- ❑ Keflex
- ❑ Latex
- ❑ Local Anesthetics
- ❑ Metal
- ❑ Penicillin
- ❑ Polymycin
- ❑ Sulfa

Notes: _____

Name, Address and Phone Number of your Primary Care Physician _____

Check all that you currently have, or have had in the past.

- ❑ AIDS/HIV Positive
- ❑ Alzheimer's Disease
- ❑ Anaphylaxis
- ❑ Anemia
- ❑ Angina
- ❑ Arthritis/Gout
- ❑ Artificial Heart Valve*
- ❑ Artificial Joint*
- ❑ Asthma
- ❑ Blood Disease
- ❑ Blood Transfusion
- ❑ Breathing Problem
- ❑ Bruise Easily
- ❑ Cancer
- ❑ Chemotherapy
- ❑ Chest Pains
- ❑ Cold Sores/Fever Blisters
- ❑ Congenital Heart Disorder
- ❑ Convulsions
- ❑ Cortisone Medicine
- ❑ Diabetes
- ❑ Drug Addiction
- ❑ Epilepsy or Seizures
- ❑ Excessive Bleeding
- ❑ Fainting Spells/Dizziness
- ❑ Frequent Cough
- ❑ Frequent Diarrhea
- ❑ Frequent Headaches
- ❑ Glaucoma
- ❑ Hearing Impaired
- ❑ Heart Attack/Failure
- ❑ Heart Murmur*
- ❑ Heart Pace Maker*
- ❑ Heart Trouble/Disease
- ❑ Hemophilia
- ❑ Hepatitis A, B or C
- ❑ Herpes
- ❑ High Blood Pressure
- ❑ Hives or Rash
- ❑ Hypoglycemia
- ❑ Irregular Heartbeat
- ❑ Kidney Problems
- ❑ Leukemia
- ❑ Low Blood Pressure
- ❑ Lung Disease
- ❑ Mitral Valve Prolapse*
- ❑ MRSA Disease
- ❑ Nervous Disorders
- ❑ Pain in Jaw Joints/TMJ
- ❑ Psychiatric Care
- ❑ Renal Disease/Problems
- ❑ Renal Dialysis
- ❑ Respiratory Problems
- ❑ Rheumatic Fever
- ❑ Shingles
- ❑ Sickle Cell Disease
- ❑ Sinus Trouble
- ❑ Spina Bifida
- ❑ Stomach/Intestinal Disease
- ❑ Stroke
- ❑ Swelling of Limbs
- ❑ Thyroid/Parathyroid Disease
- ❑ Tonsillitis
- ❑ Tumors or Growths
- ❑ Ulcers
- ❑ Yellow Jaundice

Notes: _____

SELECT ONE:

❑ **I DO NOT want any information about my dental care communicated to family members/caregivers.**

❑ **I give Sacopee Valley Family Dental permission to verbally communicate to family members/caregivers listed below.**

Name: _____ **Name:** _____ **Name:** _____

Please check the box next to the specific information that may be **verbally** communicated to the individual(s) listed above:

❑ Prescription Request ❑ Request/Confirm/Cancel Appointments ❑ Treatment Plan ❑ Financials

This authorization will be updated every 12 months. I have the right to revoke this authorization in writing at any time. Revocation will not cover information released prior to that date. If I want to grant permission to GVD to discuss any other information with anyone besides myself, I understand that I will need to complete a separate Release of Information form.

***To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____ _____

Patient/Parent/Legal Guardian Signature Date

OSSIPEE RIVER DENTAL

PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgment

I HAVE RECEIVED A COPY OF THIS OFFICE'S NOTICE OF PRIVACY PRACTICES.

Print Name:_____

Signature:_____

Date:_____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ◯ Individual refused to sign
- ◯ Communications barriers prohibited obtaining the acknowledgment
- ◯ An emergency situation prevented us from obtaining acknowledgment
- ◯ Other (Please Specify)

_____

_____

_____